1001. TSM, Chapter 3, Section 1.5, paragraph 1.6.1.4.1.2
The inquiry period used for the CC&D Totals Inquiry may be a single date or a date range, not more than three years in the past. Future dates are not valid.

Since enrollment fees are collected in advance of the new enrollment year, will a CC&D inquiry and update be available to post of these fees? (This is an existing issue today. Fees are received and held to be applied to CDCF before TMA has set the new fiscal year).

RESPONSE: Yes. As soon as the new policy is created by DEERS the MCSC may post fees. Catastrophic Cap and Deductible updates may be posted at any time.

1002. TSM, Chapter 3, Section 1.5, paragraph 1.7
OHI information can be added to DEERS or updated on DEERS through multiple mechanisms. At the time of enrollment the MCSC will determine the existence of OHI. The MCSC can add or update OHI through the DOES application used by the MCSC to enter enrollments into DEERS. Other MHS systems can add or update the OHI through the Web application provided by DEERS. In addition, DEERS will accept OHI updates from the claims processor through a system to system interface. The presence of an OHI Policy discovered during routine claims processing shall be updated on DEERS within two business days of receipt of the required information.

The TRICARE Prime Enrollment Application (reference RFP, Section J, Attachment 2) includes a question as to whether or not OHI applies to any of the enrolling family members. The application asks for the name and identification number of the other insurance. This is not sufficient information for a complete record of OHI for a person (reference TSM, Chapter 3, Section 1.5, paragraph 1.7.2). We suggest the Enrollment Application be modified to include all of the OHI questions. This will reduce the number of inquiries and development needed to obtain the complete information. Additionally, the web page (reference TSM, Chapter 3, Section 1.5, paragraph 1.2.3.) does not include OHI. Will the MCSC be able to add the fields necessary for OHI as part of the customization process?

Response: Thank you for your suggestion. At the present time we do not anticipate modifying the enrollment form to collect additional OHI information.

1003. TSM, Chapter 3, Section 1.5, paragraph 1.7
When an MHS organization is enrolling a person into a coverage plan, or updating person or patient data without the Health Insurance Carrier Name, there is a placeholder entry on the SIT that can be used to complete the process. The placeholder entry on the SIT has a value of "Unknown" and can be used to indicate that an OHI policy exists for a beneficiary. This health insurance carrier of "Unknown" has an assigned Health Insurance Carrier Identifier (ID). For "Unknown" OHI policies the default coverage indicator is "medical"; however, any coverage indicator can be assigned to it. Monthly, DEERS provides the Uniform Business Office (UBO) and the entity that provided the policy a report of the persons with an "Unknown" OHI policy. The report details the persons' information and the systems that entered the "Unknown" policy. The enrolling entity or updating system is responsible for obtaining the complete OHI information.

How will this report be received? What format will be used?

RESPONSE: This report will either be sent by or retrieved from DEERS. The exact mechanism and formats will be provided following contract award.

1004. TSM, Chapter 3, Section 1.6, paragraph 1.0
All updates to DOES must be tested by the MCSC/USFHP provider and, if operable, installed and used. Will DEERS only support the current and prior release of the DOES application?

The DOES test environment, and related companion applications, are dependent on DMDC (see Chapter 3, Section 1.7).

RESPONSE: DEERS will support only the current and the prior release. The prior release will only be supported for 30 days following the release of the next version.

1005. TSM, Chapter 3, Section 1.6, paragraph 2.1
"Problems or requests that are related to personnel or person discrepancies should be reported directly to DSO via TRICARE Enrollment Correction Request process. DMDC will provide the incoming MCSC with the process at contract award. Any issue that affects the beneficiary's immediate medical care should be indicated as "urgent". The DSO will provide assistance for resolution of issues in the areas outlined below."

a. What mechanism will be used to report personnel or person discrepancies for non-enrolled beneficiaries?

RESPONSE: A similar process is available for reporting issues with non-enrolled beneficiaries through the DEERS Support Office (DSO).

b. Upon contract award, will the MCSC be provided with a complete New DEERS Medical Data Dictionary?

RESPONSE: Yes.

c. Will the MCSC still need to reference the NED Technical Specifications, Production Problem Resolution Document and the NED Data Dictionary in addition to the TSM?

RESPONSE: MCSCs will have no need to reference any NED documents. Following contract award, DEERS will provide updated problem resolution procedures and an updated data dictionary.

1006. August 26, 2002, TOM, Chapter 7, Section 4, 2.0 CQMP Structural and Functional Requirements
The contractor shall participate in monthly, or less frequently if directed by the Regional Director, region level quality management committees...
August 26, 2002, TOM Chapter 15, Section 3, 10.0 Monthly Reports - Quality Management Activity Report
The contractor shall provide a monthly report to the Contracting Officer and the Regional Director of the activities and results of the contractor's quality management and Program Integrity Programs within ten calendar days following the end of each reporting month. In addition, minutes of the catchment area-specific clinical quality assurance committee meetings shall be forwarded to the Contracting Officer, with a copy to the Regional Director, quarterly within ten calendar days following the end of the quarter...

a. Please clarify that the region level quality management committee is the requirement as specified in TOM Chapter 7 and not catchment area-specific meetings as noted in TOM Chapter 15, Section 3.

Response: Both meetings are required as described in TOM Chapter 16, Section 1, 5.0 & Chapter 15, Section 6, 5.0

b. Does the government intend that the quality committee minutes be a quarterly deliverable and should be contained in the TOM Chapter 15, Section 5 rather than Section 3?

Response: As described in Chapter 7, Section 4, 2.0 and Chapter 15, Section 3, 10.0 the meetings are monthly or quarterly with reporting requirements which may be either monthly and/or quarterly.

1007. There is a discrepancy between TRICARE Operations Manual Chapter 1, Section 8 and Chapter 12, Section 1 for MOU requirements between the MCS contractor and the national TRICARE Marketing and Education Contractor (MKEC).

Chapter 1, Section 8 Transitions, Item 2.4.2 MOU with Marketing and Education Contractor -
"Sixty (60) calendar days after contract award, the contractor shall have executed an MOU with the TRICARE Marketing and Education Contractor, including deliverables and schedules."

Chapter 12, Section 1 Marketing and Education Requirements, Item 1.3 - "The MCS contractor shall meet with the MKEC within 60 calendar days after health care contract award to develop a MOU, develop coordination process for inclusion of regionalized and localized information in materials developed by the MKEC, identification of quantity, distribution requirements and shipping schedules for materials required by the MCS contractor."

Item 5.1 - "All TRICARE contractors shall enter into a MOU with the MKEC effective within 90 calendar days of contract award"

Please clarify with regard to completion date of the MOU between the MCS contractor and MKEC – 60 or 90 days.

RESPONSE Revised 15 November 2002

Response: We are updating Chapter 12 with new requirements. These will be published in an upcoming amendment. The new requirements will specify that the Government will meet with the contractor within 60 calendar days after contract award and that the MOU with the government must be finalized within thirty days following the initial meeting with the Government.

1008. The requirements for validity and provisional TED edits are referenced in the TOM in Chapter 1, Section 3, 1.9.1 and 1.9.2 and in the RFP, Section H-8.j and k. In these references, there is a "ramp-up" to the required performance---X percentage at 6 months and a higher X at 9 months and thereafter. As each of the old regional contracts roll into the new contracts, will the new MCSC have 9 months for each of the former regions during which to ramp-up to the required performance? e.g. For Region 11, the new MCSC will have from March of 2004 until November 2004 to

ramp up to the required performance, and for Regions 9,10,12 the MCSC will have from June 2004 until Feb 2005 and regions 7 and 8 the MCSC will have from September 2004 until May 2005.

Response: No. The MCSC must correct system problems and train staff within the period allowed based on the first start of health care delivery within each contract.

1009. TOM Chapter 7, Section 3, 1.0; NQMC. The current OPM states ".....the contractor shall provide the NQMC with hardcopies of the medical record", the new TOM language states "...the MCS contractor shall transmit copies of the medical record".
Is the intent the same? Or by 'transmit' is there a requirement for an electronic transmission of the record or something different?

Response: The word "transmit" was selected as an attempt to allow the contractor the ability to deliver records to the NQMC in the most appropriate fashion, given the nature of the record and the nature of the case to be reviewed. The intent is the same; there is no requirement for electronic transmission of the record.

1010. TOM Chapter 7, Section 3, 1.2 ; NQMC. New language"...and proposed follow-up actions to address the issues". Is it the governments intent that the contractor would propose a specific follow-up action plan monthly to each NQMC identified documentation concern i.e., "poor quality copy of the medical record, one signature missing on an order, a page in the medical record without a date, a nursing / physician signature illegible?"

Response: The TOM states that the contractor will address all discrepancies found by the NQMC, and proposed follow-up actions shall be provided. Given the concerns identified in the question, it can be expected that the contractor would indicate that it would work to ensure that good quality copies of medical records are provided, that all necessary signatures and dates are provided, and that signatures are accurate representations of the signatory's name.

1011. TOM Chapter 7 Section 1; Relating to Retrospective Review Requirements for Other than DRG Validation; It appears that a 1% Focused Review will be performed by the contractor, but the statement "...the Regional Director ...will provide the contractor with sampling criteria 60 calendar days prior to the quarter from which the review sample is drawn", conflicts with the additional statement of "The contractor shall provide the records within 45 calendar days from the date of the request." The time lines conflict.
a. Who will be performing the review?

Response: The MCSC will perform the review. We will delete the 2nd referenced sentence in an upcoming amendment.

b. Please provide an example of how the 60 days and 45 days work within one schedule. The timeline is not clear.

Response: Please see our previous response.

1012. The second part of the government's answer to question #288 regarding monthly newspaper articles for base newspapers ("Input for articles will be provided by the MCSC to the M&E contractor who will prepare the final product.") seems to

contradict TOM Chapter 12, Section 2, Introduction Paragraph (second sentence) which states, "This (beneficiary education) program shall include…the monthly submission of articles for publication in MTF/base newspapers…"

Is it TMA's intent to have the MCS Contractor forward the monthly bulletins defined in TOM Chapter 12, Section 1 which are developed by M&E contractor to base newspapers, or is the government requiring another separate "press release" type of announcement to be developed monthly by the MCS Contractor for base newspapers?

Response: Please see the revision which will be published in an upcoming amendment that will require submission of the articles to the TRICARE Office of Communications and Customer Service.

1013. Questions #53 and #799 requested clarification regarding the government's evaluation of "proposal risk" as that term is used in Sections M-4.a and M-5.a. The response to Questions #53 and #799.a indicates that proposal risk is "the identification and assessment of the risks associated with an offeror's proposed approaches to performing the requirements of the contract" or "how much risk is associated with an offeror's approach to meeting one of the subfactors."

We understand that the evaluation of proposal risk will be a subjective judgment of the evaluators. However, we assume that, at a minimum, the evaluators are given some guidelines regarding what is high proposal risk and what is low proposal risk. For example, if an offeror's approach to meeting one of the subfactors is an approach that is new and unproven, that approach may be evaluated to have a high proposal risk. On the other hand, if an offeror's approach to meeting one of the subfactors is an approach that has been previously used by the offeror and has been performed satisfactorily, that approach may be evaluated to have a low proposal risk. Therefore, in order for an offeror to demonstrate that a proposed approach is low proposal risk, the offeror would have to provide facts regarding (1) the offeror's experience in performing the proposed approach and (2) the offeror's past performance in performing the proposed approach successfully. However, since Section L.14.d.(1) states that past performance information shall not be addressed in the oral technical presentation, how are offerors permitted to present facts to demonstrate that the proposal risk is low?

In the oral presentation will offerors be permitted to address its experience and past performance pertaining to "proposed approaches to performing the requirements of the contract" in order to demonstrate low proposal risk?

Response: Yes, you have a good understanding of proposal risk and the evaluation process. For example, a candy maker, in an oral presentation, could reasonably say that they have the equipment in place with excess capacity to produce 1,000,000 candy bars per day. This equipment is supported by a fully trained staff of 200 candy makers with an average of 5 years experience that can be devoted full-time to producing the subject candy bars. We also have long established relationships with XYZ supplier who, on the next slide, has provided a warranty to provide the candy making supplies within 3 days of our request at a pre-established price.

1014. Question 477 concerns transition out payments for claims processing. The government states, "Assuming the contract extends through all 5 option periods, the claim rate for processing claims received after the start of health care delivery for

services received before the start of health care delivery of the new contract will be the CLIN for Claims Processing in OP5." We believe this is an important answer and that this should be incorporated in the contract in Section G.3.a.(3)[4](i) Transition-Out so that there is no confusion as to how claims processing is reimbursed in the transition-out periods. Please clarify.

RESPONSE: We agree to include language in G-3.a. similar to the following: "Payments for claims the Contractor receives within 90 calendar days following the cessation of health care delivery (for servies rendered during the health care delivery period) are made based on the claim rate in effect during the health care delivery period immediately preceeding transition-out. Since all claims must be processed within 180 calendar days, the Government will not pay the outgoing contractor the healthcare or administrative cost associated with claims not processed to completion within 180 calendar days from the cessation of health care delivery

1015. Please provide TRICARE Service Center workload data for each TSC. This information is necessary for us to determine the staffing required at each TSC.

RESPONSE: We have provided all TSC information available to the Government. Offerors must exercise caution in using this information as it represents workload based on a different set of requirements being accomplished using the incumbents processes. TSC staffing should be based on the offeror's model for delivery of its proposed TSC services to the population numbers provided by the Government.

1016. L-14.d.(2)
a. Will the Government provide a microphone for offerors to use during the oral presentations and question and answer sessions?

RESPONSE: Yes.

b. If yes, what type of microphone (e.g., handheld, stationary, podium, standing, clip-on, wired, wireless)?

RESPONSE: We anticipate providing a handheld, wireless microphone.

1017. L-14.d.(2)
a..Will the Government make an audio or video recording of the presentation and question and answer sessions?

RESPONSE: Yes, we will video tape the oral presentations and all question and answer sessions.

b. If yes, will the Government provide a copy to the offeror?

RESPONSE: Yes

c. If yes, when will the Government provide the copy?

RESPONSE: We anticipate providing a copy of the videotape to offerors within ten working days following the presentation.

1018. L-14.d.(2)

a. Will the Government transcribe the presentation and question and answer sessions?

RESPONSE: No, we believe the video taping creates a complete record.

b. If yes, will the Government provide a copy of the transcript to the offeror?

RESPONSE: No transcript will be created.

c. If yes, when will the Government provide the copy?

RESPONSE: Not applicable.

1019. L-14.d.(2)
The four-hour length of the oral presentation suggests that an offeror's PowerPoint presentation will be large. Not every computer would be able to run a single PowerPoint file of that size. To enable offerors to divide their presentation into files small enough so that the presentation computer to display them, please advise how much RAM the presentation computer will have.

RESPONSE: The computer will use has 256 megs of RAM. In planning their presentation, offerors should schedule time to load files during breaks as the presentation time clock will not stop to accommodate the loading of files.

1020. C-7.3.2. Is the definition of referral provided in paragraph H-8.l. ("a referral is the offer of an appropriate appointment within the access standards") the definition of referral for C-7.3.2.?

RESPONSE: Yes, the definition is the same.

1021. H-8.l.
a. Does this performance guarantee apply only to referrals from non-MTF providers?

RESPONSE: No, the performance guarantee applies to all contractor referrals regardless of the source.

b. (Incomplete question removed)

1022. Page 2 of the TNEX Systems Manual Change 2 Transmittal (published 9/25) references pages to be changed in Chapters 5, 6, 7, 8, and 11; however, the Systems Manual contains only 4 chapters. Incidentally, the provided page 2 of the Systems Manual Transmittal exactly matches page 2 of the Transmittal provided with Change 2 of the TNEX Operations Manual. Is there a corrected version of the Systems Manual Transmittal available?

RESPONSE: You are correct. We have updated the web with the correct transmittal pages.

1023. Page 3 of the TNEX Operations Manual Change 2 Transmittal instructs the user to remove Section 3, pages 3-10, and replace them with Section 3, pages 5-9. This leaves a gap of several pages. Please clarify which pages are to be removed and inserted.

RESPONSE: We will publish a new transmittal.

1024. TOM, Chapter 15, Section 3, 7.0. The last bullet requires the contractor to report the, "percentage of all referrals during reporting in which the results of the completed referral were communicated in writing to the initiating provider..."

a. Is a completed referral a referral that results in the referred patient being treated by the referred provider?

RESPONSE: No, a completed referral is a referral that resulted in the patient being seen by the provider indicated in the referral. A referral doesn't necessary result in a treatment but could results in a recommendation through a consultation report or a recommendation to the PCM of another referral.

b. Does "all referrals" include only those referrals to civilian providers, not to MTF providers?

RESPONSE: Yes, only the timeliness of the results of referrals to civilian providers should be counted.

c. Does "all referrals" include both referrals from civilian providers and referrals from MTF providers?

RESPONSE: No, it only includes referrals from civilian providers.

d. RFP paragraph C-7.1.16. requires consult reports to go to the beneficiary's primary care manager, but the Operations Manual provision requires consult reports to go to the initiating provider. In cases where the initiating provider is not the beneficiary's primary care manager, to which provider should the contractor ensure the report goes?

RESPONSE: The RFP will modified in an upcoming amendment to clarify the requirement that will indicate that reports will go to the initiating provider, not just primary care managers.

1025. C-7.3.2. This paragraph requires the contractor to refer at least 96 percent of MHS beneficiaries in Prime service areas who seek care through the contractor to an MTF or network provider. The monthly report relevant to this requirement, in the Operations Manual, Chapter 15, Section 3, 7.0., does not provide the contractor with the ability to distinguish between the number of referrals it receives and the number of MHS beneficiaries who seek care through the contractor. Not every referral the contractor receives from a non-Prime beneficiary will necessarily result in the beneficiary contacting the contractor to seek care. How will the Government identify the correct subset of referrals on which to gauge contractor compliance with the requirement in C-7.3.2. if the Government does not provide the contractor with the opportunity to note the number of beneficiaries who seek care through the contractor?

RESPONSE: You are correct; not every non-Prime beneficiary referral will result in the contractor being contacted either by the provider or the beneficiary. Paragraph C-7.3.2. requires only that 96% of all referrals that come through the contractor be referred to either the network or the MTF. The measurement involves 96% of known

referrals by the contractor, not all referrals; e.g., non-network providers referring to non-network providers directly.

1026. C-7.3.1. If the contractor receives a referral from a civilian provider for an urgent service, should the contractor offer the right of first refusal to the MTF?

RESPONSE: Yes.

1027. C-7.1.2. In amendment 0003, the Government removed the reference to the Regional Director in the MTF's process of referring a beneficiary to a non-network provider. In the Government's response to question 142, issued before amendment 0003, the Government indicated that exceptions would not involve the contractor. Will the MTF referral that the contractor receives notify the contractor of the MTF decision to refer to a non-network provider? If not, how will the contractor be able to ensure appropriate adjudication of claims as required by C-7.5.?

RESPONSE: Yes. This issue should be covered in each MTF MOU with the contractor.

1028. C-7.1.10. This paragraph requires network providers to submit all claims electronically. Many providers that currently submit electronically do so via a clearinghouse organization. If a provider submits a paper claim to a clearinghouse, and the clearinghouse submits a digital claim for processing to the contractor, then by definition the claim was submitted electronically. Please confirm that the Government agrees with this conclusion.

RESPONSE: This is acceptable as the contractor will be receiving an electronic ASC X12N 837.

1029. Would the government please consider allowing the presenter of the Oral Presentation to utilize a member of his/her team to advance the slides during their presentation?

RESPONSE: Yes

1030. Benchmark Testing

Background:

A. Section F.5.c.(3) requires that Systems Interconnections be completed 120 days prior to the start of health care delivery.

B. Section F.5.e. requires that Claims Systems Demonstration (Benchmark Test) be completed 120 days prior to the start of health care delivery.

C. TMA's answer to Question 302, referencing section F.5.c.(3) and inquiring whether the contractor has to have a fully working system with all connections tested by 120 days before health care delivery, clarifies that "the contractor must be able to fulfill the Benchmark Test requirements of the TRICARE Operations Manual."

D. TRICARE Operations Manual 6010.51-M, August 1, 2002, Chapter 1, Section 8, Transitions, 2.1, Systems Development provides:

Approximately 30 calendar days prior to the initiation of health care delivery of services, the non-claims processing systems and the telecommunications interconnections between these systems shall be reviewed by the TMA or its designees, to include a demonstration by the contractor of the system(s) capabilities, to determine whether the systems satisfy the requirements of TRICARE as otherwise provided in the contract. This includes the telecommunications links with TMA, DEERS, and MHS Referral and Authorization System. The review will also confirm that the hardware, software, and communications links required for operating the automated TRICARE Duplicate Claims System have been installed and are ready for TMA installation of the Duplicate Claims System application software (see Chapter 9 and 10). This review is in addition to Benchmark testing.

E. TRICARE Operations Manual 6010.51-M, August 1, 2002, Chapter 1, Section 8, Transitions, 2.10, Claims Processing System and Operations. During the period between the date of award and the start of health care delivery, the incoming contractor shall, pursuant to an implementation schedule approved by TMA, meet the certain specified requirements including, but not limited to, 2.10.1. Contractor File Conversions and Testing --

The incoming contractor shall perform initial conversion and testing of all ADP files (e.g., provider files, pricing files, and beneficiary history) not later than 30 calendar days following receipt of the files from the outgoing contractor(s). All ADP file conversions shall be fully tested and operational for the Benchmark.

F. TRICARE Operations Manual 6010.51-M, August 1, 2002, Chapter 1, Section 8, Transitions, 3.0 Instructions for Benchmark Testing -- 3.1.3 provides:

... All aspects of claims processing may be tested ... The contractor shall demonstrate its ability to conduct enrollment, authorization and referral, and claims processing functions ... The benchmark test may include testing of any and all systems (internal and external) used by the contractor to process claims. In addition to testing claims processing records, the benchmark will test generation and acceptance of TRICARE Encounter Data (TED) records for every test claim. ...

G. TRICARE Operations Manual 6010.51-M, August 1, 2002, Chapter 1, Section 8, Transitions, 3.4. Operational Aspects, 3.4.1 provides:

The benchmark test may be conducted on the contractor's production system or an identical copy of the production system (test system). Whichever system is used for the benchmark, it must meet all TRICARE requirements and contain all the system interconnections and features proposed for the production system in the contractor's proposal.

Issue:

TMA has made it clear that the winning contractor must "have a fully working system with all connections tested by 120 days before health care delivery", and have the ability "to fulfill the Benchmark Test requirements of the TRICARE Operations Manual". These requirements require, among other things, testing of the contractor's systems, telecommunications interconnections and all necessary hardware, software and communications links with TMA, DEERS, the MHS Referral

and Authorization, and the TRICARE Duplicate Claims Systems to ensure that they are operational.
In order to successfully perform the Benchmark Test and other reviews required by TMA, it is critical for the contractor to begin testing the interconnections and telecommunications links before the start of Benchmark testing. Given the extent and complexity of the systems involved, it could take as long as 90-180 days to establish completely new connections with a system that is not already linked to TMA systems. New entrants, some of whom may be bringing up innovative new technology, will require interface standards and data elements from TMA, as well as a test system that mirrors TMA's production system for each interconnection being tested. The Operations Manual provision on "Systems Development" referenced above is misleading and sets up an unrealistic expectation in stating that the interconnections will be reviewed only 30 calendar days prior to the start of health care delivery. Only if the interconnections are already established well before this date could a contractor satisfy TMA 30 days before health care delivery that the interconnections work. If this is not stated clearly, TMA would in effect be artificially restricting competition and limiting the source of qualified offerors by favoring incumbents over new entrants.

RESPONSE: We realize that systems development and establishment could take a considerable amount of time. We have listened to the community and have established a transition period of 10 months. Once there is an award, the transition and interface meetings all occur within the first 30 days (TOM, Chapter 1, Section 8, Paragraphs 1.2. and 1.3.) That's when the systems interconnectivity and telecommunications details to include time lines will be collaborately worked out between the government and the contractor. It is not possible to minutely list every aspect of a transition in the TOM realizing that the successful offeror will have their own approach, which the Government will attempt to accommodate. Also, the intent of the TOM, Chapter 1, Section 8, paragraph 2.1. Systems Development is not that the Government will begin reviewing the systems interconnection but this is a full (and hopefully final) review by the Government to see if all systems are "a go."

A. We respectfully suggest that TMA amend the TRICARE Operations Manual to require the contractor to begin establishing the necessary interconnections and links at least sixty (60) days before the start of the Benchmark Test.

RESPONSE: We see no need to add this instruction that essentially directs both the Government and the contractor to establish connectivity within 60 days prior to the benchmark. Depending on the contractor's proposed systems, 60 days may not be enough; it's best to leave this detail to the transitions meeting. For example, during the meeting, DEERs staff will discuss with the contractor's ADP staff their connectivity requirements to match with any DMDC software or hardware needs. Historically, when the contractor purchased the lines, DEERS connectivity occurred as quickly as 60 calendar days after award.

B. We also request that TMA create a test environment and publish sample layouts for data files necessary for the contractor to establish and test connectivity to the desired system interfaces.

RESPONSE: File layouts for DEERS transactions will be provided at the transition technical specifications meetings following contract award. During those meetings, time frames for systems connectivity and telecommunications will be negotiated between the contractor and the Government. Contractors should consider

establishing their telecommunication connections as soon as possible following the technical specifications meetings in accordance with their negotiated transition plan. DEERS will make a test region available for ongoing contractor testing and another separate test region for benchmark testing. Chapter 2 of the TSM contains file layouts for the TED records. Since testing of the contractor's ability to successfully generate and submit TED records is part of the benchmark test, contractors must have the necessary connections to the TED database test region prior to commencement of the benchmark test. Testing of the interconnectivity will also occur.

C. We further respectfully suggest that TMA amend the TRICARE Operations Manual to provide that the incoming contractor will receive all ADP files (e.g., provider files, pricing files, and beneficiary history) and other necessary data from the outgoing contractor beginning not later than 30 calendar days following contract award.

RESPONSE: The initial transfer of files occurs sooner. The outgoing contractor will transfer to incoming contractor by the 15th day following the transitions meeting (or sooner if negotiated during the meeting) all ADP files as specified in the official transitions schedule. In addition, updates to the files will occur weekly. (TOM, Chapter 1, Section 8, Paragraphs 4.3.3. and 4.3.4.)

1031. Question from the TRICARE Reimbursement Manual: (TRM) Chapter 7, Section 1, Policy III.F.3: The last sentence refers to a 21 day time frame for processing adjustments. We assume that the claims processing standards found in Chapter 1, Section 3.1.3 through Section 3.1.3.2 (30, 60 and 120 day cycle time standards) applies to all adjustment claims, please confirm.

RESPONSE: You are correct and we will correct the Reimbursement Manual in a future change.

1032. TRICARE Operations Manual Chapter 13.1, Item 9.0 –states "All contractor determinations reversed in whole or in part by the contractor's or the NQMC's reconsideration determination, the TMA formal review determination, or by a hearing final decision, shall be reprocessed by the contractor within 21 calendar days from the date of the contractor's reconsideration determination or receipt of the copy of the NQMC's reconsideration determination, the formal review determination or the hearing final decision." We assume that the claims processing standards found in Chapter 1, Section 3.1.3 through Section 3.1.3.2 (30, 60 and 120 day cycle time standards) applies to all claims being reprocessed based on appeal decisions, please confirm.

RESPONSE: You are correct and we will correct the TRICARE Operations Manual in a future change.

1033. TRICARE Operations Manual Chapter 13.6, Item 3.0 – Under 'Contractor Determinations Reversed By the Appeals Process' states 'the contractor shall reprocess all determinations reversed by a formal review determination or hearing final decision within 21 calendar days'. We assume that the claims processing standards found in Chapter 1, Section 3.1.3 through Section 3.1.3.2 (30, 60 and 120 day cycle time standards) applies to all claims being reprocessed based on appeal decisions, please confirm.

RESPONSE: You are correct and we will correct the TRICARE Operations Manual in a future change.

1034. Throughout the TRICARE Operations Manual it is noted that specific references to pharmacy claims was removed. As an example TOM Chapter 18.3, Item 2.4 – The entire section on processing of pharmacy claims was removed, along with requirements to provide all ADSMs with no-fee access to the network pharmacy system and statement that OTC meds are not covered. We assume that all current pharmacy requirements, if any requirements exist, falls to the pharmacy contractor and that the pharmacy contract will be implemented prior to or concurrently with the MCSS contracts. In other words, MCSS contractors will not be responsible for processing pharmacy claims under this contract. Please confirm.

RESPONSE: That is not entirely correct. The MCS contractors will be required to receive and process claims for certain pharmaceuticals not obtained through a retail pharmacy or the TRICARE mail order pharmacy. Please see the RFP, Section C-7.42

1035. The current version of the OPM (Chapter 21, Section 3.1.2.2 indicates that Civilian claims for non-TRICARE eligibles who are SHCP eligible (MTF inpatients referred to civilian facility) who are also TRICARE for Life beneficiaries should be processed with Medicare first without consideration of SHCP. This reference is removed in the August 1st , 2002 version of the TRICARE OPERATIONS MANUAL. We assume that DEERS will be the determining factor on how these claims should process and whether they fall under the MCSS contractors responsibility or the T.D.E.F.I.C. contract. Please confirm.

RESPONSE: Yes. The language in the T-NEX TRICARE Operations Manual, Chapter 18, Section 3, para 1.2.2. will be changed by adding the following sentences at the end of the current paragraph: "SHCP shall not be used for TRICARE For Life beneficiaries referred from an MTF as an inpatient. Such civilian claims shall be processed with Medicare first without consideration of SHCP." This will make it clear that such claims fall under the TDEFIC contract and not the MCS contracts

1036. TRICARE Operations Manual Chapter 19.3, Item 3.5 – Added a new section requiring that Claims for National Guard or Reserve sponsors with treatment dates outside their eligibility dates cannot be automatically adjudicated. Claims for ineligible sponsors are to be suspended and routed to MMSO for payment approval or denial. A notification letter (newly added Addendum C) shall be sent to the beneficiary when claims are routed to MMSO. If a payment determination is not received within the 115th day of receipt, the claim is to be denied. Does this apply to both Army and Air Force National Guard? Are there any additional reporting requirements for this process?
We assume these claims are considered non-retained while in 'MMSO' review. Please clarify.

RESPONSE: This paragraph applies to both Army and Air Force National Guard. There are no additional reporting requirements for this process. The use of the term "non-retained" is incorrect for these claims. The proper term for these claims is "excluded claims" as they are claims requiring government intervention.

1037. TRICARE Operations Manual Chapter 21. Section 2., 4.4.1.1.2 – This statement changed regarding the real-time and batch eligibility inquiries and responses between the contractors and DMDC from 'may continue in non-standard

format' to 'will be in DEERS specified format'. Will DMDC provide the format they will be using or will this continue to be in non-standard format?

RESPONSE: The terms "non-standard format" and "DEERS specified format" have the same meaning. Both mean "proprietary format" as opposed to the HIPAA ANSI ASC X12N standard transaction formats. The file layouts will be provided at contract award.

1038. The TRICARE Systems Manual, Chapter 1, Section 4.1.5, page 10, states that "All long-haul telecommunications lines communications equipment, up to an including the CSU/DSU, for the interfaces to DEERS and MHS sites shall be ordered, installed, and tested by the contractor". In the same manual, Chapter 1, Section 4.2.1.2, page 11, there is a requirement that "The Contractor is responsible for a dedicated primary and backup circuit and DEERS for claims processing". This seems to imply that the connection to DEERS will be via dedicated lines purchased, installed, and maintained by the contractor. Does this mean that the DISN or NIPRNET will not be used for this connection?

RESPONSE: The TRICARE Systems Manual, Chapter 1, Section 1.1, Subsection 4.0, "Telecommunications," has been revised. Connections to DEERS will be through the MHS DMZ Gateway. Please refer to the TRICARE Systems Manual, Chapter 1, Section 1.1, Subsection 4.1 for information regarding the MHS DMZ Gateway.

1039. The TRICARE Systems Manual, Chapter 1, Section 4.3.3.1.1, page 11, states that "The contractor shall arrange for connections to the government's data processing center". Since this section falls under the section 4.3 TMA/TRICARE Encounter data, should the contractor assume that this requirement is for TED processing only? Is the contractor required to purchase lines and equipment?

RESPONSE: The TRICARE Systems Manual, Chapter 1, Section 1.1, Subsection 4.0, "Telecommunications," has been revised. The contractor shall communicate with the government's data processing center through the MHS DMZ Gateway. Please see Subsection 4.7.3. for additional information.

1040. The TRICARE Systems Manual, Chapter 1, Section 4.5.2, page 17, addresses NIPRNET/Internet connectivity to DCS. Since this section falls under the section 4.5 TMA/TRICARE Duplicate Claims System, should the contractor assume that the NIPRNET will be used only for accessing the DCS system? If connectivity to other government systems requires the NIPRNET, please identify those systems that will use it.

RESPONSE: Contractors will gain access to the TRICARE Duplicate Claims System through the public Internet, the MHS DMZ Gateway, or both. Contractor systems that are required to interconnect with government systems shall do so via the MHS DMZ Gateway, the public Internet, or both depending on the system. Since contractors will not be connecting directly to the NIPRNET but instead will be utilizing the MHS DMZ Gateway to access government systems, it is not necessary to identify all government systems that connect to the NIPRNET.

1041. TRICARE Systems Manual Chapter 2, Section 2.4 Under the Element Name: Amount Interest Payment – indicates that interest is reported at the line level. Since the Age of a claim applies to the entire claim, we assume it is still correct to calculate interest at the header/whole claim level. Please confirm.

RESPONSE: Interest can be calculated at the claim level but since the TED record can represent payments to multiple payees, interest payments must be reported at the line item level on the TED record and it must balance to actual disbursements (header).

1042. TRICARE Systems Manual – Chapter 2, Section 6.3) - Element Name: Provider Taxpayer Number – Edit 2-240-04R is for non-institutional TED records, however, it states that the taxpayer number should match an Institutional Provider Taxpayer Number. Please clarify that this instruction is correct. Will Provider taxpayer number, major specialty, sub-identifier, and zip code be used for matching on the TMA provider database for non-institutional providers?

RESPONSE: TED edit 2-240-04R is incorrect in the TSM. All references to "Institutional Provider" should be "Non-Institutional Provider". The TSM will be amended with the next published change.

1043. TRICARE Systems Manual – Chapter 3, Section 1.3 – Under Patient Identification - States that 'The MCSC system must accommodate both the DEERS Patient ID and the HIPAA Patient ID'. What is the HIPAA patient ID and what is the format?

RESPONSE: The National Provider Identifier (NPI) has not been defined through publication of a final rule by the Centers for Medicare and Medicaid Services (CMS). Should the NPI exceed 10 bytes, the TED record will be expanded to accommodate a larger number.

1044. TRICARE Systems Manual – Chapter 3, Section 1.3 – PCM Identification - This section states that the MCSC will be responsible for providing a crosswalk from the MCSC provider ID to the national provider ID (when available). This NPI number cannot exceed 18 bytes. On the TED record, none of the reserved fields for NPI numbers are 18 bytes in length. Should these reserved fields be expanded to accommodate a number of this length?

RESPONSE: The National Provider Identifier (NPI) has not been defined through publication of a final rule by the Centers for Medicare and Medicaid Services (CMS). Should the NPI exceed 10 bytes, the TED record will be expanded to accommodate a larger number.

1045. The TRICARE Systems Manual, Chapter 2, Section 1.4, paragraph 2.2.1, page 2 indicates that DOES will use the NIPRNET. IS the "new" DEERS application to be used be the claims processor also going to use the NIPRNET?

RESPONSE: Contractors will access DEERS through the MHS DMZ Gateway and not through a direct connection to the NIPRNET.

1046. TRICARE Systems Manual – Chapter 3,– 'DEERS average response times for online updates (data push) from socket to socket connections is seven (7) seconds, and for online data queries (data pull) from socket to socket is fine (5) to eight (8) seconds'. This section also goes on to state that the average response time for DOES is four (4) to six (6) seconds. Are these response times indicative of the response time the contractor can expect for DEERS queries that will be used for

claims entry? Under the current contract, the contractors experience sub-second response time for these queries.

RESPONSE: The response times were presented as conservative estimates to assist in developing proposals. Actual response times are dependent on a number of variables to include the type and content of the transactions, network bandwidth and traffic.

1047. TRICARE Systems Manual – Chapter 4, Section 1.1 Policy states: 'The Government will operate and maintain an electronic MHS Referral and Authorization System capable of accepting and sending referrals and authorizations, including non-availability statements (NASs). The system will receive and route electronic referral and authorization transactions between various MHS direct care and purchased care entities, e.g., MCSCs and MTFs'……Will the MHS referral and authorizations data be part of DOES EITs, or transmitted by another electronic vehicle to the contractor?

RESPONSE: Referral and authorization data will not be part of DOES nor will it be transmitted through EITs. MHS referral and authorization data, including Non-Availability Statements (NASs) will be transmitted to the contractor from the MHS Enterprise-Wide Referral and Authorization System through HIPAA standard ANSI ASC X12N 278 transactions.

1048. The DEERS/Medical Interface Operational Description for MCSC, Version 1.0, dated 12/15/01, Section 4.1, page 31, states that "All systems, including DEERS, will use the DISN for the communications infrastructure". Is the DISN the same as the NIPRNET? Doesn't this requirement conflict with the language in the TRICARE Systems Manual, Section 4.1.5?

RESPONSE: The referenced DEERS / Medical Interface Operational Description for MCSCs, version 1.0, dated 12/15/01, is not part of this Request for Proposal (RFP). Contractors will access DEERS through the MHS DMZ Gateway and not through a direct connection to the NIPRNET.

1049. The DEERS/Medical Interface Operational Description for MCSC, Version 1.0, dated 12/15/01, Section 1.2.1, page 5, the government describes many system that interact with DEERS. Other than DOES, is any other system accessing the NED system to determine benefit/eligibility/health insurance information in the same manner that the contractors will be required to do so?

RESPONSE: The referenced DEERS / Medical Interface Operational Description for MCSCs, version 1.0, dated 12/15/01, is not part of this Request for Proposal (RFP).

1050. The DEERS/Medical Interface Operational Description for MCSC, Version 1.0, dated 12/15/01, Section 1.2.5, page 14, the government states that "the legacy eligibility system will be discontinues by FY 2003". Since transition activities will continue throughout 2004, will the existing MCS contractors be required to "cut over" by October 1, 2003?

RESPONSE: The referenced DEERS / Medical Interface Operational Description for MCSCs, version 1.0, dated 12/15/01, is not part of this Request for Proposal (RFP).

1051. In regards to TMA synchronizing enrollment year Cat/Cap with Fiscal year Cat/Cap and eliminating the use of Enrollment year Cat/Cap, will there be a

conversion of Enrollment Year Cat/Cap data from the MCSCs to DEERS under the existing contracts or will this be included as part of the TNEX contracts?

RESPONSE: This will be included as part of this contract. This will be addressed in a future TRICARE Systems Manual change.

1052. In the response to question # 551 on this site, shouldn't the question number reference be 85 instead of 83?

RESPONSE: Thank you, you are correct. We will correct the reference in Question 551 to reference question 85.

1053. We have noticed that on the T.D.E.F.I.C website the question sets have footers with the dates the questions and answers were posted to the site as well as listing only new questions in each posting. Would TMA consider taking this same approach with the MCSC questions and answer forum?

RESPONSE: Following the TDEFIC approach on the MCSC web site would require hosting and archiving a larger number files than our current administrative staff could handle. While we want to make the MCSC web site as useful as possible, changes in format to the site at this stage will be very difficult.

1054. In amendment 003 of the RFP, the summary of changes indicates that paragraph C-7.25.1 was added. However, this paragraph does not exist in the update changes. Please advise.

RESPONSE: The summary of changes is in error; paragraph C-7.25.1 was not added and the summary of changes will be corrected in a future amendment.

1055. Please reference RFP Section H-8.j – TED Edit Accuracy (Validity Edits). The standards listed here contradict TOM Chapter 1, Section 3.1.9.1. The RFP standard is 93% after six months of performance during the first option period and 98% for the ninth month and thereafter during the entire term of the contract. TOM requirements are 85% for the first through the third months, 90% for months four through six, 95% for months seven through nine and 99% thereafter. Please clarify which standards apply to this performance guarantee.

RESPONSE: The TRICARE Operations Manual standards apply, and the performance guarantees will be updated in a future change.

1056. Please reference RFP Section H-8.k – TED Edit Accuracy (Provisional Edits) concerning the standards. This contradicts TOM Chapter 1, Section 3.1.9.2. The RFP standard is 88% after six months of performance during the first option period and 94% for the ninth month and thereafter during the entire term of the contract. TOM requirements are 80% for the first through the third months, 85% for months four through six, 90% for months seven through nine and 95% thereafter. Please clarify which standards apply to this performance guarantee.

RESPONSE: The TRICARE Operations Manual standards apply, and the performance guarantees will be updated in a future change.

1057. Please clarify a question regarding Claim Rate Payments. In the event of an adjustment to a claim, a corrected TED/HCSR record will be submitted. Under what

conditions would the government not pay a claim rate for an adjustment? Is the government taking into account adjustments that are not due to contractor error, such as submission of late charges, corrected claims, or adjustments received from primary insurance carriers?

RESPONSE: There are no claim rate payments for adjustments. The percentage of adjustments in the total number of records submitted is very small and only a portion of those are not due to contractor error. By looking at submission types on the HCSR data tapes, an offeror can determine which claims have been adjusted and can make any desired change in the claim rate amount bid.

1058. Section C-7.1.10. of the RFP states "As a condition of participation in the contractor's network, all providers shall submit all claims electronically." The CFR Part 199.2 defines a provider as "a hospital or other institutional provider, a physician or other individual professional provider or other provider of services or supplies" as specified in the CFR Part 199.6 describing authorized providers. The TRICARE Operations Chapter 21 Addendum A defines "electronic media" as "the mode of electronic transmission. It includes the Internet (wide open), Extranet (using Internet technology to link a business with information only accessible to collaborating parties), leased lines, dial-up lines, private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disk or compact disk media." Given this information, we understand that for a claim to be considered as "electronic media", the electronic transmission of the claim must originate with the provider of services or a third party clearinghouse or vendor with which the provider has a billing services arrangement. We further understand that a claim that originates in paper format in a provider's office, is forwarded by traditional mail services to a TRICARE contractor, subcontractor or vendor, and is data entered or optically scanned into an electronic format by the TRICARE contractor, subcontractor or vendor would not be considered an electronic claim since the cost of creating the electronic claim would be included in the contractor's price. Please confirm that our understanding of the definition of an electronic claim is correct.

RESPONSE: You are correct. The contractor must receive, from what ever source (e.g., provider, clearinghouse), an electronic claim as it enters its portal and must be HIPAA compliant.

1059. Question 1. In response to Question 414, the Government indicated that it would be acceptable and reasonable to submit L-4 and L-5 Reports that are signed within 60 days of the initial submission date if the proposal date is extended. Assuming that the submission date of 10/2/02 is used, this would mean that signatures obtained on or after 8/4 would be within the 60 days. However, the Government's response to Question 615 indicated that the date of the signatures should be within 60 days of the submission of the technical and price proposals. Assuming we use the date of 11/1/02 - the original due date of the technical proposal - only signatures obtained 9/3 or later would be acceptable. Given that offerors may have a number of signatures on L-4s and L-5s obtained during the month of August, would the Government accept signatures obtained in August to prevent having to get new signatures for the Past Performance Reports?

RESPONSE: Yes. In a future amendment we will clarify that the signatures obtained must be within 60 days of the original proposal submission date.

1060. In reviewing the new TSC information we received today, we found at least one case where a facility had been included in the original files but is no longer in the new files. The Region 12 example we found is Hickam AFB, DMIS ID 0287. Any information you could share on why this facility (and maybe others) is no longer included would be helpful.

RESPONSE: Revised 12 November 2002

RESPONSE: The updated data represents the most current status of TSCs. Where no TSC information is provided, it means that a TSC, on base in this instance, has been either closed or did not exist. In the case of Hickam, there is no TSC but only a single contractor staff presence at Hickam (hence the previously reported square footage) and was eliminated as from the data as not a true TSC. That does not alter the T-Nex requirement to place a TSC at every MTF..

1061. As a follow-up to question #940, the problem with the change 2 posting for the TSM is with page 2 of the Publications System Change Transmittal document. That page lists the 'Remove page(s)' and 'Insert Page(s)' for change 2 to 6010.51-M (the TOM) - not the TSM.

RESPONSE: The transmittal sheet has been corrected.

1062. TRICARE Operations Manual, Chap. 14, Section 2, para. 2.2.1.5 states that the "Use of medical staff and/or consultants is expected and required not only for initial reviews but postpayment analyses and audit requests from TMA. Whenever the case is complex, physician consultants, with a specialty appropriate to the case, shall be involved in the review."

[a] In the current MCS Contracts, medical record audit requests from TMA are currently paid for by TMA, not the MCS Contractors. Does the Government intend that these services be paid as an Administrative Cost of the Contractor under T-NEX, rather than a cot "pass through" as is currently done?

RESPONSE: The Government intends that these services be paid as an administrative cost of the contractor under T-NEX. Regarding the offeror's comment that TMA is currently paying for medical records audits, it is the Government's position that performance of medical reviews/audits falls within the scope of the this contract and does not warrant separate reimbursement under the contract. However, subject to the Contracting Officer's approval, separate reimbursement for a medical review will be authorized only under very limited circumstances (e.g., the investigative agency requests a specific medical professional to conduct the review).

[b] If the Contractor is to be At Risk for these administrative services, does TMA have any historical data that would indicate the approximate number of audits performed annually?

RESPONSE: There are two categories of audits that need to be addressed—TMA requested audits and audits performed during a contractor's required case development process. Concerning the TMA requested audits, on an annual basis nationally, an average of not more than 20 fraud cases require specialty medical reviews that fall within the provision of Section 2., 2.2.1.5.

The following addresses audits performed during a contractor's required case development process. Based on the contractual requirements under Section 2, 2.2., the contractor shall develop cases to determine the probable method of fraud/abuse and potential dollar value of the case. A statistically valid audit shall be accomplished if there is evidence of possible fraud. [Exceptions to this requirement may include cases where a calendar audit may be performed rather than a medical audit or cases involving unbundling.] Since Chapter 14 requires medical audits be performed as part of the case development process prior to referral to TMA Program Integrity, a second medical audit will normally not be required. Please note that the Government does not have historical data on the number of cases developed by each of the current contractors versus the number of cases actually referred to TMA. We recommend the offeror refer to the Chapter 14 requirements to calculate the number of cases the offeror is expected to generate from the use of commercial anti-fraud software and rely on the operational procedures they are required to have in place for developing cases of potential fraud/abuse.

We also recommend that offerors utilize the data found on our fraud website[www.TRICARE.osd.mil/fraud/]. The "Referral" site contains a listing of all fraud/abuse case referrals received from the current managed care support contractors and our dental contractor since calendar year 2000.

[c] Is there any data that would reflect volumes by Region (i.e. average number of records to be reviewed, average number of claims, and average cost per audit)?

RESPONSE: See our response to Question [b] above.

[d] Will the Government guarantee that the volume of these requests remain relatively constant?

RESPONSE: The Government cannot guarantee that the volume of these requests will remain relatively constant due to the very nature of health care fraud/abuse.

[e] Without the information requested in [b] through [d], how does the Government expect the bidder to reasonably estimate the administrative costs involved?

RESPONSE: There is considerable information available at the TRICARE website www.TRICARE.osd.mil/fraud/. That, plus the above, covers a period of several years and should allow an offeror to reasonably estimate administrative costs involved in performing medical audits.

1063. TRICARE Operations Manual, Chap. 14, Section 2, para. 2.2.1.5 states "Medical necessity audits must be performed by registered nurses, or equally qualified medically trained staff, who can make medical judgements based on professional education and experience. This means RNs or qualified physician's assistants for medical claims."
Will the Government give consideration for a Certified Medical Records Coder to perform audits? For example, in certain situations where there are upcoding or unbundling suspicions, a Certified Medical Records Coder is more qualified to perform such audits.

RESPONSE: Historically, TMA Program Integrity has required the services of qualified medically trained staff be provided when performing medical necessity audits. However, the Government will give consideration for coders to perform audits

depending on the circumstances surrounding the case. For example, the Government will take into account the allegations/issues involved, the complexity of the audit to be performed, and DOJ's requirements prior to stipulating the type of reviewer that will be required to perform the audit. As allowed by the TOM, Chapter 14, Section 2, if the offeror can demonstrate to the Government the coder's qualifications for performing audits on unbundling or upcoding cases, the Government will take this under consideration. Please note that some upcoding cases require a physician's review. TMA Program Integrity maintains the authority to instruct the contractor as to the type of reviewer required to perform an audit in the cases in which TMA is requesting the audit.

1064. TRICARE Operations Manual, Chap. 14, Section 4, para 5.1.3. states "In cases involving potential patient harm, contractors shall individually notify those patents (or their parents or guardians if under age 18 or incapacitated) who are affected." Contractor legal counsel has a concern with the liability issue in writing beneficiaries based on accusations.

a) Can the Government be more specific in when these individuals are to be contacted? Is it prior to or after conviction or before or after State suspension of the provider's license to practice? Is a sample letter available?

RESPONSE: The contractor shall take appropriate action, as spelled out in the TOM, Chapter 12, Section 4., paragraph 5.1.3. governing beneficiary notification, if, in the opinion of the contractor, any potential issue, problem, or circumstance arises that poses a threat to the health, safety, and welfare of beneficiaries, poses a significant problem in utilization of services, or concerns the quality of health care services delivered to our beneficiary population. It is a subjective decision on the part of the contractor.

Regarding the concern of contractor legal counsel with the liability issue in writing beneficiaries based on accusations, the Government's position is that notification shall be accomplished after this information is "public knowledge" [e.g., indictment issued, media reports, newspaper articles, trade publications, etc.]. TMA Program Integrity is not advocating the letter be "accusatory" in nature. The intent, as stated in 5.1.3., is to alert patients who may be impacted so they can seek appropriate care. For a sample, we recommend the offeror review the Office of the District Attorney, Marin County, CA letter on the website. Notification can consist of forwarding the public notice to the beneficiary.

TMA Program Integrity is available for consultation, on a case-by-case basis, regarding patient harm issues.

b) The Contractor would prefer to release a situation-specific Government created letter on DoD letterhead to the applicable beneficiary population that has been determined from Contractor claims files. In this way, the Government is responsible for the content of the letter and the Contractor is responsible for to whom it is delivered.

RESPONSE: As an agent of the Government, the responsibility for issuing notices shall remain with the contractor. As stated in the response to 1064 [a], TMA Program Integrity is available for consultation, on a case-by-case basis, regarding patient harm issues.

1065. TRICARE Operations Manual, Chap. 15, Section 3, para 10.0. "The contractor shall provide a monthly report to the Contracting Officer and the Regional Director of the activities and results of the contractor's quality management and Program Integrity Programs within ten calendar days following the end of each reporting month."

a) Please confirm that this is a new requirement.

RESPONSE: This is a requirement of the solicitation 906-02–R-0006.

b) Is there some reason why this Program Integrity report is not contained in Chapter 14, Program Integrity, dated August 1, 2002?

RESPONSE: This report is more than a program integrity report but deals with multiple quality management issues.

c) Please identify the intended content and format of the report.

RESPONSE: The minimum content required is listed in the TOM, Chapter 15, Section 3, paragraph 10.0. The format is unspecified, but would contain a series of tables and narrative explanations.

1066. We understand that a waiver has been granted to allow for increased CMACs in Alaska. If true, when did this waiver occur? What is the nature of this waiver? In particular, were the CMACs increased directly, or were claims well above (more than 15% of) CMAC considered to be allowed amounts? If providers in Alaska are allowed to bill more than 115% of CMAC, is the difference between CMAC and the new allowed amount an allowable health care cost?

RESPONSE: CMACs were increased in Alaska. On February 1, 2000, a new locality was created that encompassed all areas of Alaska except Anchorage. The last increase occurred July 1, 2002. which was for Anchorage, except for mental health providers. . Now all of Alaska is on average 28 percent higher than the Medicare payment levels. This means that the CMACs have been raised directly on average 28 percent in hopes that there will be an increase in the access to care. The balance billing provision (115 percent of the allowed amount) still applies. The increased CMACs are now allowable health care costs. The balance billing amount of an additional 15 percent would not be an allowable amount, except in the case of active duty members.

Background information for questions 1067 to 1077

RFP Section B, CLIN 1107AA-$2,000,000 (Government Provided Estimate-Fixed Fee): C-7.7.1. states: "The contractor shall operate programs designed to manage the health care of individuals with high-cost conditions or with specific diseases for which proven clinical management programs exist. These programs shall be available to TRICARE eligible beneficiaries authorized to receive reimbursement for civilian health care per 32 CFR 199 and active duty personnel whose care occurs or is projected to occur in whole or in part in the civilian sector. When care occurs within an MTF, the contractor is responsible for coordinating the care with the MTF clinical staff as well as the civilian providers. The contractor shall propose medical management programs and patient selection criteria for review and approval of the Regional Administrative Contracting Officer prior to implementation and annually thereafter."

1067. Based upon the *2001 Sherlock Expense Evaluation Report*: *Public Companies Edition,* the average per member per month medical management costs was $1.93. Based upon the average MHS eligibles, the annualized cost would equal $37 million in each region. Even if 50% of this expense was related to case and disease management the total annualized expense would be over $18 million.

a. How does the U.S. Government anticipate the contractor to implement their best practices and offer best value healthcare when the RFP limits this amount to only two million dollars in 2004?

RESPONSE: It is important to understand the military health system and the differences between this system and the costs projected in the *2001 Sherlock Expense Evaluation Report*: *Public Companies Edition.* For instance, the contractor is not responsible for TRICARE beneficiaries who receive 100% of their services in the MTF. Second, the contractor is not responsible for applying the full range of offeror proposed medical management techniques to TRICARE Prime enrollees with MTF PCMs or TFL eligible beneficiaries. The report also addresses a different demographic than is seen in the TRICARE population. These factors significantly change the cost per eligible. Nevertheless, the Government is revising this CLIN in a future amendment to move case management to the PMPM and to increase the dollar amount available to the Regional Managers for disease management. Offerors must understand that the Government is not obligated to expend funds for disease management. The decision on which programs to approve will be made in accordance with the RFP.

b. Given the increased commercial expenditures for medical management how does the Government intend to evaluate health care expense when proven case management has been limited?

RESPONSE: Please see our previous response. The Government is moving case management to the PMPM which eliminates the concern expressed.

1068. The operations manual includes a definition of Case Management, as follows:

"A collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services to meet an individual's health care needs using resources available to provide quality and cost-effective outcomes. Case Management is not restricted to catastrophic illnesses and injuries."

Is this definition applicable to the case management/disease management CLIN?

RESPONSE: Case management will be included in the per member, per month CLIN in an upcoming amendment. The definition will apply to case management.

1069. Does the Government have a similar definition of Disease Management (and if so, what is it)?

RESPONSE: No, a Government specific definition is not required, as the term is well understood within the industry. What is important to recognize is that the contractor may propose disease management programs to the Region at any time as we expect these programs to change with advances in medicine.

1070. Reference C-7.7.1: What are the criteria to be used by the Regional Administrative Contracting Officer for approval of proposed programs? If cost (including whether the cost exceeds $2,000,000) is one of these factors, how is that to be weighed against other factors (such as impact on population health, health care cost avoidance, etc.)?

RESPONSE: As mentioned in the answer to question 1067, the CLIN will be amended to remove case management and the dollar amount will be increased. The Government will not specify criteria which limit the Region's ability to determine which proposals result in the best value to the Government based on the situations. This is why the disease management programs must be re-evaluated annually.

1071. Reference C-7.7.1: "The contractor shall operate programs designed to manage the health care of individuals with high-cost conditions of specific diseases for which proven clinical management programs exist." In this context, what should programs be "proven" to do (e.g., be cost effective, be clinically effective)?

RESPONSE: Proven programs are cost-effective because they mitigate the need for treatment either through proper management of a condition or through actual improvement in the specific condition being treated. In all cases they improve the well-being of the patient.

1072. Clause C-7.7.1 appears to describe the proposal process for disease management programs in CLINs 0105AA and other related CLINs. What is the process for approving case management programs in these same CLINs?

RESPONSE: Case management is a requirement of the RFP. Since the Government is moving case management to the PMPM CLIN, offeror's must include their proposed approach to case management in their proposals.

1073. May case management or disease management programs be included in CLINs 0104AA and related CLINs as initially proposed by the contractor?

RESPONSE: Please see our previous responses.

1074. If a contractor submits a program under clause C-7.7.1 which is not approved, may a contractor implement the program at its own cost?

RESPONSE: No. However, the offeror may propose a no cost disease management program to the Region's management.

1075. Reference C-7.7.1 and M-8.b (1). The government will perform a cost realism analysis of the proposed target cost to determine the "probable cost of performance." In performing this cost realism analysis, how will the government make assumptions regarding whether case management and disease management programs proposed by the offeror will be implemented?

RESPONSE: As changed by solicitation amendment, offerors shall include any costs related to "case management" in their proposed PMPM administrative costs, thus assuring the offeror that their proposed plans for case management will be under their control as far as implementation is concerned. Offerors should also consider any resulting impact to the health care costs within their proposed target cost buildups. As for disease management, the Government cost estimates established in

Section B have been increased by solicitation amendment. The RFP states that the estimated disease management costs are not commitments from the Government. Consequently, the RFP instructs offerors not to assume any savings in their target health care cost buildups.

1076. Reference Question 388. This answer makes it clear what offerors should propose in their administrative price. May offerors make assumptions about the likely programs to be implemented under this CLIN for purposes of their healthcare proposal?

RESPONSE: See answer to Question 1075.

1077. If a proposed case management/disease management program is not approved by the Regional Administrative Contracting Officer (RACO) and therefore not implemented, and that failure by the RACO causes healthcare costs to exceed those proposed by the contractor, will the non-approval constitute a change order to the approach proposed by the contractor and agreed to by the government through contract award? If not, how can the contractor prepare (and the government evaluate) the option one year health care price, since the health care cost is highly dependent upon the maintenance and improvements to the case management practices that are inherent in historic TRICARE claims data?

RESPONSE *Revised 29 November 2002*
RESPONSE: Please see the response to Question 1075.

1078. It is critically important we receive a definitive list of the government-designated MTF locations so we can identify Prime Service Areas and required TSC locations. Your 9/25/02 response to question #811 and your 10/10/02 response to question #956 state that you are posting documents (Power Point) that contain a map of all military MTFs, both inpatient/outpatient and outpatient (clinics) only. Our representatives who attended the 3 October 2002 Service overview briefings did not receive such a map. When are the maps being posted on the MCSS solicitation web site?

RESPONSE: The maps have been posted.

1079. We believe there are serious errors in the data you have provided for Prime Non-Catchment area zip codes for Region 1. Of the first 39 zip codes listed, only one is valid for the city listed according to the US Postal Service zip code look-up engine. The remaining 38 zip codes are either invalid, or are for a city other than the one listed in your data. Offerors cannot develop a competitive proposal without accurate information from the government. Will the government determine the validity of these data and provide the offerors with a corrected file?

RESPONSE: We agree. New information will be provided as soon as possible.

1080. In your response to question #811, you state, "Prime is required in all MTF catchment areas (to include clinics) and BRAC sites." There are no clinic catchment areas identified in the TMA Data Package. We believe the clinic catchment areas may be included but not specifically identified in what you refer to as Prime Non-Catchment files. It is important that offerors be able to differentiate the clinic catchment areas from the true Prime Non-Catchment areas because, according to your answer to question #663, new contractors are not required to continue offering

TRICARE Prime in non-catchment areas. It is extremely urgent at this late date that the offerors be given clear direction as to where the premier service under this contract (i.e., TRICARE Prime) is required. Will you provide a zip code file which identifies all clinic catchment areas in the United States?

RESPONSE: The term catchment area was inappropriately used. The contractor is required to offeror TRICARE Prime in a 40 mile radius around all MTFs . An MTF is defined a military medical treatment facility which includes clinics. These facilities are included on the maps posted on the web site. Offerors may use commercial off-the-shelf mapping software to determine a 40 mile radius.

1081. Section L advises that the Past Performance narrative shall not exceed 25 pages. Please confirm that this page limit is exclusive of the Title Page, Table of Contents and List of Figures.

RESPONSE: No, the page limit includes all pages in response to Section L-14.f(2)(b).

1082. The Government has requested that contractors submit a significant amount of information in their oral presentations. We are concerned that four hours is not adequate time to respond to all of the requirements of Section L, and describe our measurement techniques for every performance standard. There are literally hundreds of standards. There is a requirement to present a written document for Performance Standards. Would the Government consider allowing contractors to describe their performance measurement methodology within the written performance standards document in lieu of presenting detailed performance standards in the oral presentation?

RESPONSE: No, the Government does not want this information in the written proposals. However, in an upcoming amendment we will be extending the time for oral presentations and reducing the amount of material the offeror must present.

1083. Your response to question #811 states: "Prime is required in all MTF catchment areas (to include clinics) and BRAC sites." Does this include any of the 31 US Coast Guard clinics which have been assigned DMIS IDs? If it does, will the government provide zip code listings to identify the clinic catchment areas?

RESPONSE: Yes, Prime is required around the Coast Guard clinics with DMIS IDs. The use of the word "catchment area" was inappropriate in the earlier response. This is because catchment areas technically only exist around bedded facilities. Offerors may use commercial mapping software to determine the zip codes in a 40 mile radius around clinics.

1084. C-7.3.2 requires the 96% of referrals of MHS beneficiaries residing in TRICARE Prime service areas who seek care through the contractor, shall be referred to the MTF of a civilian network provider. H.8.l requires that 96% of contractor referrals within a Prime service area shall be to a MTF or a network provider with an appointment available within the access standards.

Please clarify the apparent disparity between referral activity described in the two RFP elements listed above. C-7.3.2 requires that MHS beneficiaries who reside in a Prime service area should have 96% of the referrals that they seek through the contractor referred to the MTF or civilian network. In that case, a beneficiary that

resided in a Prime service area but traveled to a remote area in another region who contacted the contractor for a referral while travelling there would be part of that universe of referrals. On the other hand, H.8.l says that beneficiaries who contacted the contractor about receiving care in the Prime service area should be referred to the MTF or civilian network provider 96% of the time. In this group, a beneficiary need not reside in the service area, but would request services within the service area and expect to get a network referral 96% of the time. We believe the H.8.l task was also intended in C-7.3.2 and that C-7.3.2 is in error. Are we correct? If so will the Government Amend the RFP?

RESPONSE: Section H-8.l is in error. The RFP is being amended in Section H.8.I. to reflect the provisions of Section C-7.3.2.

1085. C.7.5 - The government's response to Questions 822a and 822b indicate the scope of the contractor in making medical necessity determinations for the MTF enrollee is limited to only the inpatient admission when the length of stay exceeds the MTF's initial authorization. Additionally, it is indicated there is no responsibility for the contractor to provide medical necessity review for the outpatient determinations of the MTF Commander. TOM, Chapter 7 Section 2 provides a list of services that require preauthorization for all care and procedures listed.
a. Does this list only apply to non-MTF enrollees?

RESPONSE: No, it applies to all non-active duty beneficiaries. The responsibility for these preauthorizations rests with the MTF. The contractor is responsible for ensuring that these preauthorizations are properly entered into the contractor's systems to ensure proper claims processing and associated services.

b. If this list applies to both non-MTF enrollees and MTF enrollees, can we assume this is a medical necessity review conducted by the contractor? Is this assumption correct?

RESPONSE: No, the MTF will conduct the medical necessity review for MTF enrollees with the exception of those situations specifically listed. For non-MTF enrollees, yes, the preauthorization requirement is a review for medical necessity and appropriateness.

c. Review activities conducted by case management as covered in C-7.7.1 include medical necessity determinations. It is understood that the case management program proposed will cover the ADSM and MTF enrollee and will include medical necessity determinations. Is this assumption correct?

RESPONSE: No, case management is a collaborative activity between the primary clinician, specialists, ancillary providers, equipment providers, etc. When the primary clinician is an MTF clinician as is the case for ADSMs and MTF enrollees, the MTF's clinician's decision supercedes the case manager's recommendation. The principles of case management apply, however, to the civilian sector. We fully expect a collaborative, team effort that will result in fully acceptable plans to all parties, including the patient.

1086. C-7.19, Page C6 - "The contractor shall ensure that all contractor personnel working in DoD Medical Treatment Facilities meet the MTF-specific requirements of the facility in which they will be working and comply with all local Employee Health

Program (EHP) and Federal Occupational Safety and Health Act (OSHA) Bloodborne Pathogens (BBP) Program requirements."

Is it the government's intent that contractor personnel working in TSCs (located within an MTF) meet this requirement, or is this requirement specific to personnel working directly in clinic settings (i.e. Resource Sharing personnel)?

RESPONSE: The requirement applies to all personnel. However, offerors should be aware of the fact that MTF requirements for administrative personnel may differ significantly from the requirements for clinical personnel.

1087. H-8.1. TMA's response to Question 826 indicated that non-network usage for the traveling beneficiary and portability were not excluded from the measurement in achieving the 96% of referrals to MTF or network providers. The requirement in C-7.1.4 states, "The contractor shall inform the government within 24 hours of any instances of network inadequacy relative to the Prime and/or Extra services areas and shall submit a corrective action plan with each notice of an instance of network inadequacy." How is a corrective action plan for each instance of network inadequacy applicable for the traveling beneficiary or in circumstances involving portability?

RESPONSE: The corrective action plan is not applicable to traveling beneficiaries. It may or may not be applicable to situations involving portability. For instance, if a beneficiary is moving into a Prime service area and there are not sufficient primary care managers, a corrective action plan is required. If the beneficiary is moving to a different MCSC Region, a plan is not required from the losing contractor.

1088. Section H-8.i. The final sentence states, "This amount will be based on the actual claims audited in the quarterly TMA audits as specified in Section H." Section H.11.a.(1)(d).[4] states, "The audit process (for the payment samples) projects universe value based on the audit results." In the performance guarantee in H-8.i, will the withhold amount of the performance guarantee be assessed only on payment errors in excess of the standard or the actual claims in the sample? In other words, is the performance guarantee in Section H-8.i applied only to the specific claims in the sample and not extrapolated to the universe of claims?

RESPONSE: The performance guarantee in Section H-8.i. is only applicable to claims in the sample. The Government will not extrapolate to the universe when administering this specific provision.

1089. Section H.11.a.(1).(a). states, "Samples will be drawn on a quarterly basis from TEDS which pass TMA validity edits." TEDS that fail relational edits are provisionally accepted into the database. To be provisionally accepted, they must have passed TED validity edits. We assume that provisionally accepted TEDS will be excluded from the audit sample since they are already known to contain an error. Is that correct?

RESPONSE: Yes, provisionally accepted records will be excluded**.**

1090. The response to question number 85c, regarding section H.5.d, states "in calculating the extrapolated amount due the Government, the contracting officer will consider the net of both over and under payments." When will RFP section H.5.d be amended to reflect this change"

RESPONSE: The RFP will not be changed. The portion of the response to question number 85c quoted above is an error and will be corrected.

1091. Referral activities are discussed in several places throughout the RFP.

Reference RFP Section L.14.e (1)(a)[2] and related Section C.7.3 - This RFP reference requires that we talk about "how the offeror's referral management processes will direct all MHS beneficiaries to the MTF when capability and capacity exists and how the offeror will support this process through its network management activities."

In the National Defense Authorization Act for Fiscal Year 2001 (NDAA 01), Section 728 addresses the removal of prior authorizations for certain referrals. Specifically, a provider who is a part of the managed care support contractor's (MCSC) network is no longer required to obtain prior authorization from the MCSC before referring the patient to a specialty provider as long as that specialty provider is also in the MCSC's network. We need to clarify whether/how this law influences the T-Nex RFP. The language in the current T-Nex requirements strongly suggests that referrals will occur commonly and be an important part of the optimization effort while NDAA 01 Section 728 language specifically prohibits this activity. It is important to note that Section 728 applies to TRICARE contracts entered into by the Department of Defense after the date of enactment of NDAA 01. The date of enactment for NDAA 01 is October 6, 2001 and therefore would apply to the next generation of contracts. Please explain this apparent conflict.

NDAA 01 - SEC. 728. PRIOR AUTHORIZATIONS FOR CERTAIN REFERRALS AND NONAVAILABILITY-OF-HEALTH-CARE STATEMENTS.

(a) Prohibition Regarding Prior Authorization for Referrals--(1) Chapter 55 of title 10, United States Code, is amended by inserting after section 1095e the following new section:

``Sec. 1095f. TRICARE program: referrals for specialty health care

``The Secretary of Defense shall ensure that no contract for managed care support under the TRICARE program includes any requirement that a managed care support contractor require a primary care or specialty care provider to obtain prior authorization before referring a patient to a specialty care provider that is part of the network of health care providers or institutions of the contractor.''

RESPONSE: There is no conflict. The NDAA prohibits preauthorizations in limited circumstances. It does not eliminate referral management. Certainly network providers can refer in these circumstances without preauthorization. However, it is the MCSC's responsibility to ensure that these referrals are to the MTF before a civilian provider is considered.

1092. What is the current technology behind the TriCare web site?

RESPONSE: It is not clear what TRICARE website is being referred to or what is meant by this question? Please clarify the question and re-submit it.

1093. The Tricare Operations Manual, Chapter 1, Appendix 1, NIPRNET Customer Connection Process. C1ADA.PDF, Section 11.d. states that "the contractors network must be a closed system. There shall not be any (connections to other networks...) including the Internet." This will impact our ability to make real-time information available to enrollees via the Web as well as the cost of the solution. Will we be able to request a waver to this requirement and if so, under what conditions will a waiver be granted?

RESPONSE: We believe that the reference in this question is to the TRICARE Systems Manual, Chapter 1, Addendum A which has been removed.

1094. The policy statement of FAR 27.402, which applies to all executive agencies (see FAR 27.400 (a)), recognizes that:

"Contractors may have a legitimate proprietary interest (e.g., a property right or other valid economic interest) in data resulting from private investment. Protection of such data from unauthorized use and disclosure is necessary in order to prevent the compromise of such property right or economic interest, avoid jeopardizing the contractor's commercial position, and preclude impairment of the Government's ability to obtain access to or use of such data. The protection of such data by the Government is also necessary to encourage qualified contractors to participate in Government programs and apply innovative concepts to such programs. In light of the above considerations, in applying these policies, agencies shall strike a balance between the Government's need and the contractor's legitimate proprietary interest."

FAR 27.400 (a) acknowledges that "[d]ue to the special mission needs of the Department of Defense (DOD) and as required by 10 U.S.C. 2320, the remainder of the DOD policies, procedures, and instructions with respect to rights in data and copyrights and acquisition of data are contained in the DOD FAR Supplement (DFARS)."

DOD policy is "to acquire only the computer software and computer software documentation, and the rights in such software and documentation, necessary to satisfy agency needs." DFARS 227.7203-1(a).

Section I, at I.52, incorporates by reference FAR 52.227-14 RIGHTS IN DATA-GENERAL (JUN 1987), without any alternate provisions, rather than the DFARS clauses governing acquisition of rights in computer software and technical data. Would the Government consider incorporating the more specific DOD clauses governing acquisition of rights in technical data and computer software instead of FAR 52.227-14 RIGHTS IN DATA-GENERAL (JUN 1987) as is currently stated?

RESPONSE: We have considered your recommendation and decline to change the RFP.

1095. Section F makes reference to a "Claims System Demonstration (Benchmark)" to occur 180 days prior to the start of health care delivery. Please provide additional information regarding the objectives and scope of that Demonstration. For example, are all interfaces to be demonstrable at that time?

RESPONSE: Yes, in accordance with the TRICARE Operations Manual, Chapter 1, Section 8. If you have a specific question not addressed in the reference, please submit the specific question.

1096. Please clarify who will process run-out claims? If it is the terminated contractor, how long will they process run-out claims?

RESPONSE: The TRICARE Operations Manual will be updated through a future amendment to include the following language: "The incoming contractor shall be responsible to process non-network claims, for dates of service prior to the start of health care delivery, that are received by the outgoing contractor later than 90 days following the end of the Outgoing contractors period of health care delivery, or as agreed to at the Transition Meeting. These claims shall be forwarded to the incoming contractor by the outgoing contractor by overnight delivery, within 48 hours of receipt"

1097. Will the contractor have access to encounter data for services provided outside of the contractor's domain, e.g. MTF encounter or pharmacy encounter data?

RESPONSE REVISED 25 November 2002
RESPONSE: Please see the answer to Question 1230.

1098. Will the contractor have either direct access to CHCS or to the data in CHCS?

RESPONSE: The MCSC will not have direct access to CHCS. Please see our previous response regarding data.

1099. Should the C2 specifications or the later NSA/NIST specifications be followed or both? Which takes precedence in the case of conflicting specifications? Both are mentioned in the RFP, and other government documents reference the NSA/NIST and FIPS specifications. Where does the National Information Assurance Partnership (NIAP) fit in, if at all?

RESPONSE: Both the C2 and the cited NIST specifications (FIPS) must be followed. We do not see where a conflict exists between the C2 specifications and the specified NIST standards. The C2 specifications address implementation of information assurance security requirements. NIST develops and generates national technology standards. We do not believe the NIST standards that DoD has adopted conflict with implementation of C2 requirements. There are no applicable NSA specifications.

1100. Systems Manual Chap. 1, Section 1.1, Paragraph 4.1.1 states: "The primary communication links shall be via IPSEC virtual private network (VPN) tunnels between the contractor's primary site and the DEERS primary site and between the contractor's primary site and the MHS primary sites." However, Systems Manual Chap. 1, Section 1.1, Paragraph 4.5.2.2, DCS Connectivity Requirements, states: "All network traffic will be via TCP/IP over NIPRNET connections wherever feasible; otherwise, the public internet will be used." Will the contractor be required to connect to MHS applications via NIPRNET?

RESPONSE: Please note that the TRICARE Systems Manual, Chapter 1, Section 1.1, Subsection 4.1.1 has been revised to read, "All contractor systems that will

communicate with DoD systems will interconnect through the established MHS DMZ Gateway.”